

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-050181

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3787

STATE FILE NUMBER

FILED JAN 3 1964

VS 300
Rev. 4/59

1 H002

2 H00X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b	c. CITY OR TOWN <u>Overland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. County Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10311 Maddox</u>		
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>E.</u> Last <u>Cottrell</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1963</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1929</u>	9. AGE (last birthday) <u>34</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatch Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Gas</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Martin Cottrell</u>		13b. MOTHER'S MAIDEN NAME <u>Effie Dees</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>Yes Korean War</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>St. Louis 14, Mr. Mart Cottrell 10311 Maddox</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Brain Damage</u>						
DUE TO (b) <u>Gunshot wound of head</u>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Self inflicted gunshot wound of head</u>				
20c. TIME OF INJURY Hour <u>10:15</u> p.m. Month, Day, Year <u>12/11/63</u>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>in car parked in drive-way at home premises</u>	20f. CITY, TOWN, OR LOCATION <u>Overland</u>	COUNTY <u>St. Louis</u>	STATE <u>Missouri</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Raymond H. ...</u> Coroner			22b. ADDRESS <u>Clayton, Missouri</u>		22c. DATE SIGNED <u>12/16/63</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	DATE <u>12-14-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>McLaughlin 2301 Lafayette Ave. St. Louis 63104</u>		25. DATE RECD. BY LOCAL REG. <u>12-12-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>			

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James R. Chapman*
Licensed Embalmer No. 4552
P. O. Address *St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.